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DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 55

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Subchapter 1

General Requirements

37.55.101 DEFINITIONS (1) "Claimant" means a person applying for assistance from the ESRD.

(2) "End stage renal disease" means severe kidney disease or kidney failure which is irreversible and permanent, and which requires dialysis or kidney transplantation to control uremia and maintain life.

(3) "EOB" means an explanation of benefit form.

(4) "ESRD" means the end-stage renal disease program administered by the department pursuant to chapter 692 of the 1983 session laws.

(5) "Family unit" means the individuals who are dependent upon a common primary source of financial support, including, but not limited to:

(a) the claimant,

(b) the claimant's spouse,

(c) the claimant's natural or adopted children under 18 years of age, and

(d) when the claimant is under 18 years of age, the claimant's natural or adoptive parents and the claimant's siblings living with them.

(6) "Third party" means a public or private agency which is or may be liable to pay all or part of the medical costs of a claimant, including, but not limited to, medicare (Title XVIII of the Social Security Act), medicaid (Title XIX of the Social Security Act), a county fund for the medically needy, private insurance (including group health, private health, or family health carried by an absent parent, if applicable), the veteran's administration, CHAMPUS (civilian health and medical program of the uniformed services), the Indian health service of the U.S. public health service, and the rehabilitative services of the department of public health and human services. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Subchapter 2

Benefits and Application

37.55.201 APPLICATION PROCEDURES (1) A new applicant must:

(a) submit an application to the department in writing on the form and in the manner prescribed by the department together with all income information and documentation supporting eligibility; and

(b) ensure that the application's witness and certification of economic need statements are signed prior to submission of the application.

(2) Application forms may be obtained from the department.

(3) Upon receipt, an application will be reviewed by the department to determine if it is complete. If it is not complete, the department will request the information lacking.

(4) The department will notify a claimant of the approval or denial of his application as soon as possible after the department receives either it or all the information needed to complete it.

(5) The claimant must provide the department with a new written application for the continuation of program benefits at the end of the period during which the claimant is entitled to benefits, as determined in ARM 37.55.202. If the department receives the new application and can verify continued eligibility before the current benefit period expires, benefits shall continue uninterrupted provided funding is available.

(6) Upon being determined eligible, the claimant will receive an ESRD identification card and identification number which may be referred to by vendors in the billing process. In order to be valid, the card must be signed on the reverse side by the claimant and countersigned by a person authorized to sign for the ESRD. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 1987 MAR p. 1790, Eff. 10/16/87; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

37.55.202 TIME PERIOD FOR BENEFITS (1) An approved application entitles the claimant to ESRD benefits, to the extent the ESRD appropriation allows, for the following periods:

(a) for July 1 to June 30 of each fiscal year. Benefits shall begin in the month following receipt of and approval of the claimant's application. Retroactive benefits are not available;

(b) if a claimant's application is originally denied, or the claimant's circumstances change in such a way as to impact eligibility during any fiscal year, the claimant may submit a new application and the department will reconsider its eligibility determination. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 1987 MAR p. 1790, Eff. 10/16/87; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Rules 03 through 05 reserved

37.55.206 NOTICE OF END OF ESRD BENEFITS (1) Whenever it appears that the ESRD appropriation for the fiscal year in question will be used up before the end of that fiscal year, the department will provide a news release to each major wire service serving Montana announcing the imminent cessation of benefits and individual notice of the cessation to each person approved for ESRD participation and to each renal dialysis center within Montana. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Subchapter 3

Eligibility

37.55.301 NON-FINANCIAL ELIGIBILITY REQUIREMENTS (1) In order to participate in ESRD, the claimant applying for benefits must:

(a) have medical verification of end-stage renal disease from a licensed physician who is board eligible or certified in nephrology or a related specialty;

(b) be on dialysis or have received a kidney transplant;

(c) be a resident of the state of Montana; and

(d) participate in medicare part A and part B or have written documentation from the social security administration that the claimant is not eligible for social security benefits (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 1987 MAR p. 1790, Eff. 10/16/87; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Rule 02 reserved

37.55.303 FINANCIAL ELIGIBILITY REQUIREMENTS (1) In order to participate in ESRD, the claimant must take all reasonable steps necessary to apply for and exhaust any and all third party benefits, other than ESRD, to which the claimant is or may be entitled.

(2) If costs of treatment for end stage renal disease remain unpaid after the claimant has exhausted all other third party benefits, ESRD will pay the following benefits, provided funds are available:

(a) for claimants whose family unit's income is 200% of federal poverty level or less, ESRD will pay the claimant's unpaid costs for treatment of end stage renal disease or $1000 per month, whichever is less, except the ESRD will not pay medicaid copayments or medicaid deductibles for the claimant;

(b) for claimants whose family unit's income is between 200% and 300% of federal poverty level, ESRD will prorate the available benefits by determining the percentage of income over 200% of federal poverty level and applying that percentage to the benefit cap of $1000 per month except the ESRD will not pay medicaid copayments or medicaid deductibles for the claimant;

(c) for claimants whose family unit's income is over 300% of federal poverty level, no benefits are available from ESRD. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Subchapter 4 reserved

Subchapter 5

Services and Supplies

37.55.501 ELIGIBLE SERVICES AND SUPPLIES: GENERAL

(1) The department, to the extent of its appropriation for ESRD, will pay for the costs listed in ARM 37.55.502 for approved ESRD-eligible individuals only if each service or supply is directly related to end stage renal disease, medically necessary, ordered by a physician, and provided after the time the individual's application has been approved by the department. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

37.55.502 ELIGIBLE SERVICES AND SUPPLIES (1) ESRD will pay for the cost of each of the following services and supplies which remains after all available third-party benefits have been utilized to pay for them:

(a) For home or center dialysis:

(i) insertion and maintenance of access site;

(ii) physician and hospital service for maintenance of home dialysis;

(iii) the following medications, not exceeding a 30-day supply:

(A) hepatitis vaccine;

(B) gamma globulin;

(C) whole blood;

(D) hyperphosphatemia (phosphate binder) drugs;

(E) hypocalcemia drugs;

(F) vitamins, iron, and/or folic acid;

(G) vitamin D preparations;

(H) hypertensive drugs;

(I) diuretics;

(J) antibiotics for peritonitis associated with peritoneal dialysis.

(b) For home dialysis patients only:

(i) training the patient to implement and maintain home dialysis (excluding room, board, and travel expenses);

(ii) modification of existing plumbing and wiring, at the cost represented by the lowest of three bids submitted to the department, or, if three bidding sources are not reasonably available to the patient, the lowest of those bids available;

(iii) for those patients choosing to let a facility provide and maintain dialysis supplies and equipment (medicare method I), the charge per run by that facility;

(iv) for those patients choosing to obtain and maintain their own home dialysis supplies and equipment (medicare method II):

(A) rental and/or purchase of dialysis machine and supplies;

(B) repairs to dialysis equipment.

(c) For a renal transplant patient:

(i) preliminary medical work-up for donor/donee match for a dialysis patient who is otherwise program-eligible;

(ii) in the case of a cadaveric transplant, if ESRD is notified within 72 hours after the patient is admitted to a hospital for the transplant, transportation of the patient to and from the site where the transplant takes place, at the least expensive commercial rate available for the trip on the day of transplant; the above notification must be by the physician or social worker at either the transplant center or the dialysis facility;

(iii) physician and hospital care related to transplant surgery;

(iv) the following medications not exceeding a 30-day supply:

(A) immunosuppressants;

(B) steroids;

(C) hypertensives;

(D) diuretics.

(v) medical follow-up services which are directly related to maintenance or monitoring of the transplanted kidney. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 1987 MAR p. 1790, Eff. 10/16/87; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Rules 03 and 04 reserved

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37.55.505 NON-ELIGIBLE SERVICES (1) The cost of the following services and supplies is not eligible for payment from ESRD:

(a) attendant or back-up person;

(b) drugs not specifically listed in ARM 37.55.502 as eligible medications;

(c) transportation for anyone other than a cadaveric transplant patient;

(d) out-of-state dialysis care unless the care is directly related to a kidney transplant or a medical referral has been made by the patient's managing Montana nephrologist;

(e) any transportation for living related donor;

(f) services provided which are not related to kidney condition, e.g., epistaxis, otitis media, diabetes, eye examinations, and heart evaluations;

(g) medicare premiums;

(h) hospital in-patient care of over 60 days unless specifically justified as ESRD-related (e.g., not due to chronic debilitating disease other than renal disease);

(i) access-site surgery prior to initiation of dialysis treatments; and

(j) medicaid copayments or medicaid deductibles. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 1987 MAR p. 1790, Eff. 10/16/87; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Subchapter 6 reserved

Subchapter 7

Claims Procedures and Payments

37.55.701 DOCUMENTATION OF CLAIMS (1) A claim for ESRD reimbursement, in order to be reimbursable, must contain, or be accompanied by, the documentation required by this rule.

(2) Each claim for any reimbursable service or supply must contain:

(a) the patient's name and address; and

(b) the provider's federal tax identification number.

(3) A physician service claim must be:

(a) submitted and itemized on a completed universal health insurance claim form approved by the American medical association's council on medical services; and

(b) have a completed medicare EOB and an EOB from any private insurance which the patient might have which covers the service in question attached.

(4) A hospital service claim (inpatient or outpatient) must be:

(a) submitted on the universal hospital insurance form approved by the health insurance association of America and accepted for hospital use by the American hospital association; and

(b) have an itemized statement, medicare EOB, and an EOB from any private insurance which the patient might have which covers the service in question attached.

(5) A claim for dialysis supplies must have an itemized statement from the supplier, proper invoice numbers, medicare EOB's and the EOB's from any private insurance which the patient might have which covers purchase of the supplies in question attached.

(6) A drug/pharmacy claim must be submitted on the medicaid MA-5 form or, in the case of a hospital pharmacy, the MA-5 form or the appropriate medicare form.

(7) A claim for any ESRD-eligible service or supply other than one of those listed in (2) through (5) above must be submitted with an itemized statement or bill, plus a medicare EOB. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 1987 MAR p. 1790, Eff. 10/16/87; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

37.55.702 CONDITIONS OF CLAIM PAYMENT (1) Payment of a claim will be made only when the amount payable by ESRD exceeds $20.

(2) Payment will be made, subject to (5) below, directly to the provider for that portion of the cost of eligible services or supplies which does not exceed either the amount allowed by medicare for the particular service or supply or the actual costs, whichever is less.

(3) Payment will be made only after all other reasonably available sources of payment, such as medicare or private insurance, have either paid in part or denied payment for the services or supplies.

(4) Payments for drugs will be made, subject to (5) below, only to the extent that the charges do not exceed the average wholesale price specified in the drug topics redbook for the specific drug. The department hereby adopts and incorporates by reference the most current version of the "Annual Pharmacists' Reference", referred to as the drug topics redbook which contains the average wholesale prices for most commercially available drugs. A copy of the drug topics redbook may be obtained from Drug Oradell, New York 07649. The average wholesale price for drugs used to treat end stage renal disease may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, ESRD Program, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(5) Benefit payments may not exceed $1000 per month per eligible claimant. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 1987 MAR p. 1790, Eff. 10/16/87; AMD, 1991 MAR p. 1004, Eff. 6/28/91; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Rules 03 and 04 reserved

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37.55.705 PRIORITY OF PAYMENT (1) To the extent of the ESRD appropriation for a given fiscal year, bills received by the department during that fiscal year will be paid according to the date ESRD receives them, the first bills received being the first paid. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; TRANS & AMD, from DHES, 2000 MAR p. 1660, Eff. 6/30/00.)

Subchapters 8 and 9 reserved

Subchapter 10

Hearing and Appeal Procedures

37.55.1001 RIGHT TO RECONSIDERATION OF ADVERSE END STAGE RENAL DISEASE PROGRAM DECISION (1) Any claimant who is aggrieved by an adverse department end stage renal disease (ESRD) action on an application may, upon request, have an informal reconsideration in accordance with the procedures prescribed for informal reconsiderations in ARM 37.5.311. The informal reconsideration is not subject to the contested case provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA or, except as provided in this rule, the provisions of 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 50-44-102 and 53-6-202, MCA; IMP, Sec. 50-44-102 and 53-6-202, MCA; NEW, 1984 MAR p. 41, Eff. 1/13/84; AMD, 2000 MAR p. 1653, Eff. 6/30/00; TRANS & AMD, from DHES 2000 MAR p. 1660, Eff 6/30/00.)

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